| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155446 | A. BUILDING 00<br>B. WING | 06/14/2011 |

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| COVINGTON MANOR HEALTH AND REHABILITATION CENTER | 5700 WILKIE DRIVE<br>FORT WAYNE, IN46804 |

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| F0000 | This visit was for the Investigation of Complaint IN00091338.<br><br>Complaint IN00091338- Substantiated, Federal/state deficiencies related to the allegations are cited at F241, F279, and F282<br><br>Survey dates: June 13, 14, 2011<br><br>Facility number: 000476<br>Provider number: 155446<br>AIM number: 100290870<br><br>Survey team:<br>Ann Armey, RN<br><br>Census bed type:<br>SNF/NF: 130<br>Total: 130<br><br>Census payor type:<br>Medicare: 16<br>Medicaid: 86<br>Other: 28<br>Total: 130<br><br>Sample: 8<br><br>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.<br><br>Quality review completed on June 20, 2011 by Bev Faulkner, RN. | F0000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| F0241 SS=D | The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.<br>Based on interviews and record review, the facility failed to promptly answer a call light resulting in an incontinence episode.<br>This deficiency affected 2 of 5 residents interviewed on the East Hall.<br>(Resident #F and #G)<br><br>Findings include:<br><br>On 6/14/11 at 10:00 a.m., Residents # F and #G, who were identified as interviewable by the facility, were interviewed and indicated they had both experienced a long call light wait the previous evening, on 6/13/11.<br>Resident #F indicated she waited 40 minutes, from 8:50 p.m. to 9:30 p.m., for her call light to be answered so she could use the bed pan. She indicated she had to wet the bed because no one responded to her light.<br>Resident #F indicated she was wet "all the way up and down" and this made her feel bad because she had been taught as a child not to wet the bed. She further indicated, the nurse who eventually responded to the | F0241 | F 2411. The facility has not observed any mood or behavioral changes with residents #F and #G. Neither resident has had any furthers concerns regarding call light response time.2. The facility' s resident council met on 6/23/2011 with no complaints voiced regarding staff call light response.3. Licensed staff will be reminded to use the on call nurse to assist with staffing issues when not able to remedy within the facility. DON/designee will monitor compliance 5x weekly. The IDT will monitor through resident interviews during routine rounds.4. Results of audit will be forwarded to QA&A monthly for tracking and trending for 3 months then quarterly thereafter. | 07/01/2011 |

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| | light was "flustered," did not apologize and told her she did not have enough help. Resident #F indicated she needed help because she had a fractured pelvis.<br><br>Resident #G, who was Resident #F's roommate, indicated she wanted to go to the bathroom, during this same time, but no one responded to her light and she had to wait as well. She indicated when the nurse responded, she had to insist that the nurse take her to the bathroom. Resident #F indicated "I don't like arguing with the staff about going to the bathroom." Resident #F said the nurse was flustered because all the lights were on and there was no one there to help.<br>The residents indicated they informed the morning nurse on 6/14/11, about the problems they had last evening.<br><br>The clinical record of Resident # G was reviewed on 6/14/11 at 10:10 a.m., and indicated the resident was admitted to the facility on 6/4/11 with diagnosis which included right knee injury and overactive bladder.<br>The admission nursing assessment, dated 6/4/11, indicated the resident required assistance with toileting/transfer and was alert and oriented to person, place and time.<br>The initial care plan for fall risk, dated 6/5/11, indicated the resident was to be | | | |

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| | encouraged to use the call light.<br>The bowel and bladder assessment, dated 6/7/11, indicated the resident was continent of urine and stool.<br><br>The clinical record of Resident #F was reviewed on 6/14/11 at 10:30 a.m., and indicated the resident was admitted to the facility on 6/9/11, with a diagnosis which included but was not limited to displaced, fracture of the inferior pubic ramus.<br>The admission assessment, dated 6/9/11, indicated the resident required assistance with transfer/toileting.<br>The bowel assessment, dated 6/9/11, indicated resident #F had a Foley catheter and was continent of bowel.<br>The initial care plan, dated 6/9/11, indicated the resident was to have the "call light within reach and answered promptly."<br>Physician's orders, dated 6/13/11, indicated, the resident's Foley catheter was to be discontinued.<br>Nursing notes, dated 6/13/11 at 5:00 a.m., indicated the resident was alert and oriented and was continent of bowel and bladder.<br><br>On 6/14/11 at 10:45 a.m., the ADON (Assistant Director of Nursing), who was also the unit manager on the East Hall, was interviewed and indicated she made rounds each day but had not | | | |

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| | been told there had been a concern with call light response on 6/13/11, during the evening shift.<br><br>On 6/14/11 at 12:00 noon, the DON (Director of Nursing) was interviewed. The DON indicated she called the evening nurse, who worked on Residents #F and G's hall on 6/13/11, and determined the evening nurse sent the aide she was working with home because the aide was sick.<br>The DON indicated the evening nurse did not ask for assistance. The DON indicated staff could have been pulled from other halls and the on-call supervisor was available to help but the evening nurse "took it upon herself not to ask for help."<br><br>This Federal tag relates to Complaint Number IN00091338.<br><br>3.1-3(t) | | | |

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| F0279 SS=D | A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.<br><br>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.<br><br>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).<br>Base on observation, interviews and record reviews, the facility failed to revise the care plan for a resident with exit seeking behaviors (Resident #B).<br>This deficiency affected 1 of 3 residents reviewed with inappropriate behaviors in a sample of 8.<br><br>Findings include:<br><br>1. The closed clinical record of Resident #B was reviewed on 6/13/11 at 11:00 a.m., and indicated the resident was admitted to the facility on 4/27/11, with diagnosis which included vascular dementia with depression. | F0279 | F 279<br>1. Residenti#B's elopementi assessmenti and care plan were updatied tio reftecti his currenti stiatius as stiatied in tih2567.<br>2. Social Services will review all residentis elopementi risk assessmenti/care plan tio ensure accuracy and revise as appropriatie<br>3. Licensed stiaft and Social Services were educatied tio updatie tihe elopementi assessmenti,tcare plan ftor residentis witih exiti seeking behavior and implementi intierventions as appropriatie Social Services will monitior compliance tihrough behavior notiftcation reviews 5x weekly.<br>4. Resultis oft auditi will be | 07/01/2011 |

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| | The elopement assessment, dated 4/27/11, indicated the resident was not at risk of elopement.<br><br>On 5/9/11 at 6:30 p.m., a late entry was made in the nursing notes for 5/8/11, which indicated Resident #B was given PRN (as needed) Haldol, 5 mg intramuscularly. The note indicated "...Res (resident) was anxious, hitting, trying to get out of the facility, res also moved into unwanted places with his wheelchair, after trying to talk to resident to calm him down and taking him to his room, the PRN medication was administered et (and) was effective..."<br><br>The Behavior Notification to Social Services report, dated 5/8/11, indicated "Resident was trying to get out of the building..."<br><br>On 5/9/11, the Haldol was discontinued.<br><br>An elopement care plan, dated 5/11/11 (three days after the incident), indicated the resident was to have an electronic sensor device to alert staff to exit attempts.<br>However, the device was not ordered until 5/13/11 (five days after the resident displayed exit seeking behavior). On 5/13/11 a physician's order was obtained which indicated "wanderguard D/T (due | | ftorwarded tio Q&A montihly ftor tiracking and tirending fto3 montihs tihen quartierly tihereafter | |

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| | to) elopement risk."<br><br>The resident's risk for elopement was not reassessed until 5/13/11( five days after the exit seeking behavior was first noted).<br><br>Nursing notes indicated the resident continued to display exit seeking behaviors as follows:<br>On 5/15/11 at 3:00 p.m., the resident was pulling doors open and setting off the alarms.<br>On 5/16/11 at 8:30 p.m., the resident opened the emergency exit door two times.<br><br>There was no documentation to indicate interventions were immediately developed to address Resident #B's exit seeking behavior when it was first noted on 5/8/11.<br><br>On 6/14/11 at 2:30 p.m., the Social Service staff person was interviewed. She indicated she was aware of the Resident B's behaviors on 5/9/11, the day after the incident. The Social Services staff person indicated exit seeking and agitation were not typical behaviors for Resident #B. She indicated the interdisciplinary team did meet and an order was obtained for a wanderguard.<br><br>The elopement and missing resident | | | |

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| | policy, revised 10/09, provided by the DON (Director of Nursing) on 6/14/11 at 3:10 p.m., indicated<br>"...The Interdisciplinary Team (IDT) is responsible for identifying residents at risk for elopement, implementing preventive measures to reduce risk...,<br>Review residents identified to be 'at risk' ...with significant changes in condition, to ensure on-going evaluation and adequate plan of care....<br>Initiate interventions to address resident's elopement risk..<br>If wandering or exit seeking behavior is identified for any resident who previously has not exhibited this behavior, a change of condition IDT Walking Rounds should be completed..."<br><br>This Federal tag relates to Complaint Number IN00091338.<br><br>3.1-35(d)(2)(B)<br>3.1-35(b)(1) | | | |
| F0282 SS=D | The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. | | | |

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| | A. Based on interview and record review, the facility failed to assure the proper medication was sent home with a discharged resident. This deficiency affected 1 of 3 residents whose closed clinical records were reviewed. (Resident #B).<br><br>B. Based on record review, interview and observation, the facility failed to follow the care plan for combative behavior for 1 of 3 resident's reviewed with combative behavior in a sample of 8. (Resident #E)<br><br>Findings include:<br><br>A. 1. The closed clinical record of resident #B was reviewed on 6/13/11 at 11:00 a.m., and indicated the resident was admitted to the facility on 4/27/11. The resident was discharged to home on 5/27/11.<br><br>On 5/18/11, physician orders indicated Effexor/velafaxine (a medication used for depression and anxiety) was to be discontinued and Lexapro (a medication used for depression), and Risperdal (a medication used for behaviors) were to be started.<br>The medication changes were noted on the May 2011 MAR (Medication Administration Record). | F0282 | F 282 1. Resident #B's POA was contacted regarding the discontinued medication. Resident #E has not exhibited any changes in mood or behavior.2. During the survey, the facility performed an audit of residents discharged home to ensure the proper medication was sent home. 3. Licensed staff was inserviced to compare the discharge medication list with MD orders and the printed pharmacy sheet prior to sending home with the resident. Nursing staff were inserviced on Behavior interventions including but not limited to Responding to resistance during ADL care. UM/designee will monitor compliance through discharge audits 5 x weekly. SDC/designee will monitor compliance through random care observations 3x weekly.4. Results of audit will be forwarded to QA&A monthly for tracking and trending for 3 months then quarterly thereafter | 07/01/2011 |

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| | On 5/27/11, physician orders indicated "may discharge to home c (with) meds (medications)."<br><br>The Discharged Resident Medication Transfer Record, dated 5/27/11, indicated 28 tablets of the discontinued medication Effexor/venlafaxine were sent home with the resident with instructions to take 75 mg each day.<br><br>On 6/13/13 at 1:45 p.m., the DON (Director of Nursing) was interviewed regarding the discontinued Effexor being sent home with Resident #B. The DON indicated, the pharmacy sent a refill of the Effexor to the facility on the day Resident #B was discharged, the medication was mistakenly scanned and sent home with the resident. The DON indicated the nurses should have checked each medication sent with the resident against the medication administration record.<br><br>B.1. The clinical record of resident #E was reviewed on 6/13/11 at 2:30 p.m., and indicated the resident was admitted to the facility on 3/21/11 with a diagnosis which included but was not limited to, Alzheimer's dementia.<br><br>Resident E's care plan, dated 4/11, indicated the resident had behaviors of | | | |

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| | hitting, slapping and pinching.<br>Interventions for addressing the behaviors included, in part:<br>Providing re-direction,<br>Providing diversion,<br>Removing from the situation when combative and<br>Providing a calm environment.<br><br>The Behavior/Interventions Monthly Flow Record for June 2011, indicated the resident had a behavior of physical abuse and indicated the resident should be redirected, removed from the situation and provided with a calm environment.<br><br>Nursing notes on 6/5/11 at 7:00 p.m., indicated the resident had a brownish-purple bruise on the right forearm measuring 5.5 cm by 6 cm and purple bruising on the right anterior thumb measuring 6 cm by 4 cm.<br><br>An abuse investigation, initiated on 6/5/11, indicated Resident #E stated that two black nurses were rough and twisted her arm. The investigation indicated bruises were noted on her right arm on 6/5/11 at 5:00 p.m.<br>X-rays taken of the right arm, wrist, elbow and hand on 6/5/11 were negative for fractures. The investigation determined that Resident #E was combative during a.m. care on 6/5/11. | | | |

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| | The aides who provided the resident's a.m. care, on 6/5/11, were suspended pending investigation.<br><br>Witness statements from the investigation included but were not limited to the following:<br>CNA #1 indicated Resident #E was combative when she and CNA #2 were providing care. Resident #E was hitting CNA #2 in the stomach and she could not remember if CNA #2 held the resident's hand or if the resident hit the side rail.<br>CNA #2 indicated Resident #E was swinging the whole time they were getting her up. CNA #2 indicated the resident hit her in the stomach but she did not remember if she held her arm or if the resident hit her arm on the side rail.<br>On 6/6/11, an inservice training was provided for CNA #1 and CNA #2 which indicated if residents were resistant to care they should be reapproached at a later time or have another staff person attempt care.<br>The conclusion of the investigation indicated the facility was not able to substantiate abuse.<br><br>CNA #2 was interviewed on 6/14/11 at 10:30 a.m. CNA #2 indicated she and CNA #1 were trying to wash resident #E's "privates" and trying to put on her pants and shirt during the morning of 6/5/11. | | | |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| | The CNA indicated the resident was hitting and swinging throughout her care. The CNA indicated she had been taught to walk away when residents were combative and she did stand back. The CNA indicated Resident #E was hitting her but it did not hurt so they continued with the care because the resident was soiled. She could not remember if she told the nurse on duty about the incident but she thought she did.<br><br>On 6/14/11 at 11:30 a.m., Resident #E was observed during a Hoyer (mechanical lift) transfer conducted by LPN #3 and CNA #4. The resident was co-operative and the transfer went well. The bruises on the resident's arm and hand were fading.<br><br>CNA #4 was interviewed on 6/14/11 at 11:40 a.m. CNA #4 indicated Resident #E had been combative with her. She indicated the resident was more likely to be combative when she was tired and if she had to wait to get back to bed. The aide indicated, when Resident #E was hitting, she would ask her nicely to stop and if she continued she would back off and come back later. She felt this approach worked most of the time.<br><br>The Social Service staff person was interviewed on 6/14/11 at 2:30 p.m. The social service staff indicated, when | | | |

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|---|---|---|---|
| | 155446 | A. BUILDING 00<br>B. WING | 06/14/2011 |

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| | residents were combative, staff should make sure residents were safe, remove themselves from the situation, allow the resident to calm, obtain assistance and reapproach.<br><br>CNA #1 was interviewed on 6/14/11 at 2:45 p.m.<br>the CNA indicated Resident #E was hitting CNA #2 the entire time she was providing pericare and also when her clothes were being changed. The CNA indicated they tried to hurry and finish her care so she would calm down. She did not notice any bruises and she couldn't remember if she told the nurse about the resident's combative behavior.<br><br>There was no indication the resident's care plan for combative behavior was followed during the incident on 6/5/11 in regards to providing diversion, removing the resident from the situation and providing a calm environment.<br><br>The DON was interviewed on 6/14/11 at 3:30 p.m., and indicated the facility had annual mandatory behavior management inservices with the last inservice conducted between 4/18/11 and 5/8/11. The DON<br>indicated they did not have a specific policy for combative residents but did have a best practice facility behavior | | | |

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| | management program that indicated "...When a problematic behavior is observed the following will occur:<br>a) Remove the resident/s from immediate danger if necessary<br>b) attempt appropriate interventions/redirections..."<br><br>This Federal tag relates to Complaint Number IN00091338.<br><br>3.1-35(g)(2) | | | |